An Overview of ACH Transition Subcommittee Responses to Discussion Guidance Questions

90% response rate of public members
Public members represent consumers, private providers, and State agencies)

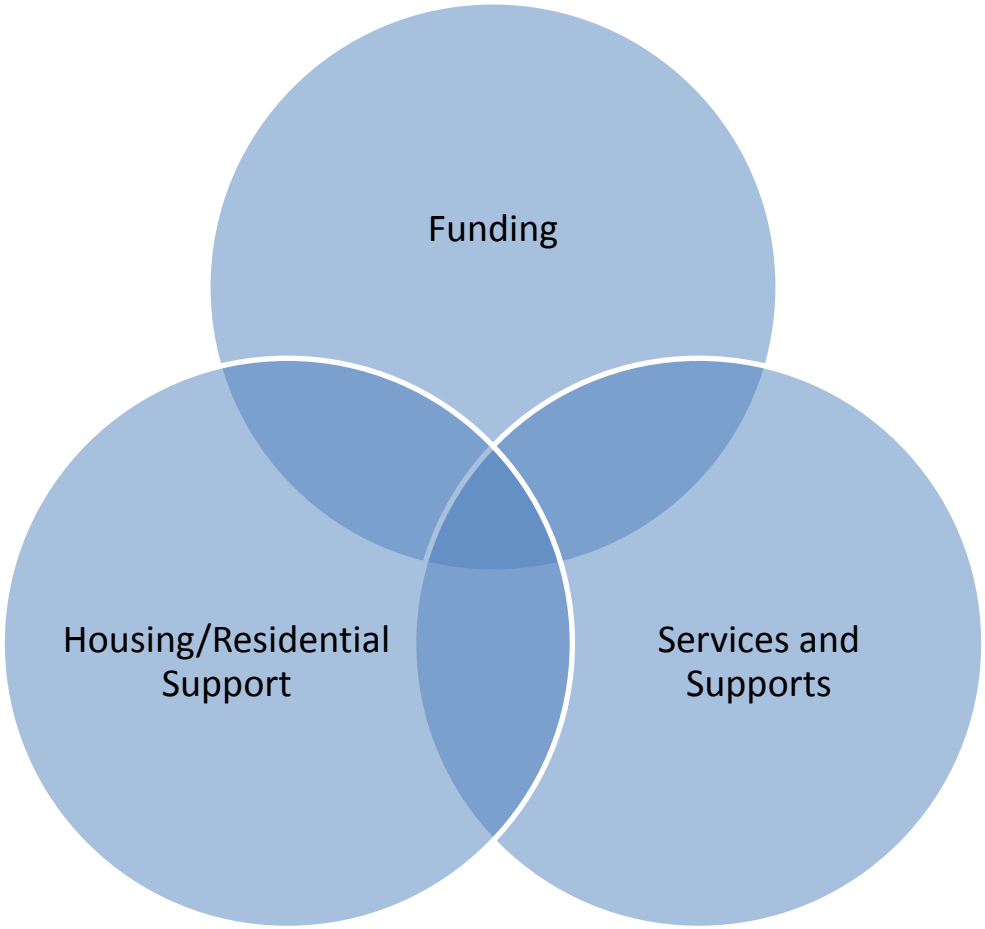
ACH Transition Committee Guidance Questions

- What do you see as the most important priority for the work of this Subcommittee? What outcome would you most like to see and why?
- If you could design a safety net to assure that those with mental illness do not fall through the cracks as we undergo the changes related to IMD designation, PCS eligibility changes and the DOJ agreement, what would that look like?
- Answer the same question for those who **do not** have mental illness and who currently reside in the Adult Care Homes or in Assisted Living facilities who may be affected by the facility's designation as an IMD.
- It has been noted that many people will not be eligible for PCS under the new definition. The "new eligibility requirements are only new for the ACHs as they are the requirements that must now be met for IN-Home PCS. It is true that in the Adult Care Homes many people would not have qualified for continued payment of PCS even under the most generous eligibility criteria. These individuals do not need personal care services. What other service definitions would be useful to provide support for the services these individuals DO need?
- Do you have questions that you would like to have clarified by presentations in subsequent meetings of this subcommittee? We have considered the following, please let us know which ones of these you would like to hear more about and add to the list –
  - SA for people in ACH and In-Home, current legislative changes and effect on Medicaid eligibility
  - Interpretation of the new eligibility requirements for PCS
  - Role of Peer Supports
  - Issues related to criminal background of individuals with Mental Illness and community housing

All respondents are concerned about…

- Individuals with MI, IDD and/or elderly people becoming homeless
- Individuals with “no assets” not being able to obtain needed Medicaid-funded services
- Needing to develop a State-plan to avoid these outcomes
- All transitions are made as smoothly as possible and with the best possible outcomes

The majority of responses fell into 3 categories of suggestions, with great overlap



Funding

- State should appropriate emergency/time limited funding until appropriate options are available and/or until a person's social security funds could be accessed
- Shift the state match from reduced PCS and the reduction in spending from case management to support outcome focused provider contracts
- Stabilize funding
- Use sub-capitation model
- Change the rule that requires that all the earnings of the individual except for the $55 per month be paid toward cost of care

Housing/Residential Support

- License providers/agencies rather than sites
- Provide housing vouchers with ensured services
- Amend DHSR rules & A1 A2 laws which negatively impact providers and individual rights
- Develop models for shared living, “hub and spoke,” and central location for meal prep, socialization etc.
- Support individuals to successfully live where they want to live.

Services and Supports

- Redefine PCS for persons with MI, e.g. assistance with medications or behaviors rather than use current definition which is based on ADLs for elder care
- Fund life-skills assessment and training and individualize services and supports. Include overall “transition services.”
- Require services to be outcomes and evidence-based, and use benchmarks and dashboards to track progress
- Link medical management and MH treatment
- Provide peer support, supported employment, residential support services, psycho-social rehab., i.e., be holistic in treatment approach

Services and Supports, cont'd.

- Expand NC START teams, Mobile Crisis Management, create Community Treatment Teams
- Provide toolkits and programs to help people stop smoking
- Provide personal response systems as needed
- Add new service definitions to support people in independent living and group homes
- Address custodial and protective service needs, and counseling/respite for families assuming/reassuming caregiving responsibilities.

Services for Individuals in ACH

- Require Geriatric Specialty Team (already funded and in place) consultation on all residents who have had psychiatric Emergency Department visit or psychiatric hospitalization, as well as for new residents with a history of mental illness
- Require that all people with MI, IDD or Substance Abuse Disease be assessed to determine what they actually need

What respondents would like to know more about:

- "I" and "K" waiver options (3/5 respondents)
- How group homes are funded
- How currently available HUD programs will be affected if no action is taken
- Solutions, effective models
- SA for people in ACH and In-Home, current legislative changes and effect on Medicaid eligibility
- Interpretation of the new eligibility requirements for PCS and qualifying for services. Could definition of group living list types of needs such as med management, ongoing cueing, etc. and shift the funds? (2/5 respondents)
- Role of Peer Supports/Specialists: effective models
- Issues related to criminal background of individuals with Mental Illness and community housing
- Plans for displaced people

Additional Questions

- How will rehabilitation and support services be funded for these individuals that lose Medicaid? If North Carolina extends Medicaid eligibility to 133% of poverty, will this be enough for these individuals to qualify for Medicaid benefits?
- How will LME/MCO's be funded to manage the activities required to implement the state's plan to address the IMD issue, the DOJ settlement, and the loss of Personal Care for specialized populations?

Additional Suggestions

- Advocacy
  - If necessary, advocate (with our representatives in Washington) that programs that are 16 beds or less not be considered IMDs under any circumstances. Possibly secure a joint statement/resolution representing the position of stakeholders, Including members of the Blue Ribbon Commission.
- Professional Development
  - Revamp training requirements and include a focus on owners/administrators. Person-centered care training by certified trainers should be an emphasis, but facilities should also be required to demonstrate examples of how they engage in this type of care that can verified.
  - Training for the Ombudsmen in the needs of people with mental health, intellectual/developmental disabilities, and substance abuse needs and appropriate services should be included in a comprehensive plan to address the adult care home system.
  - Offer GHEST training to group home staff and management

Additional Suggestions

- The most immediate priority is to dispel any misconceptions and to address the situation involving residents of 5600 group homes (A&C) for persons with mental illness and intellectual/developmental disabilities
- Promote general public awareness and acceptance of this transition of persons to other community living arrangements to assure that this is seen as a ‘community initiative’
- There needs to be accurate, real-time, personal accounting of the total affected population
- Look at person-centered transition planning models such as in Maryland and Georgia